

REACTIVATED/UPDATED PATIENT INFORMATION FORM

Please inform front desk of any changes to contact or insurance information. Date: Date of Birth: Select one: o **New Condition – I am currently under care with a new condition. o **Returning Patient** – I am returning for care after a period of inactivity. Current symptoms: _ 1. When did you first notice your current symptoms? _____ 2. How often do your symptoms occur? ___ Constantly ___ Intermittently 3. Rate your pain on the scale below. 4. Where does it hurt? Mark the area(s) on the illustration below. "X" for current pain. 2 10 Hurts Hurts Hurts Hurts Hurts Hurt Little Bit **Little More Even More** Whole Lot Worst 5. Quality of symptoms: (What does it feel like? Mark "X" all that apply) ___ Numbness ___ Tingling ___ Dull ___ Aching ___ Shooting LEFT RIGHT LEFT ___ Stiffness ___ Cramps ___ Sharp ___ Burning ___ Stabbing Other: 6. Does the pain radiate to other areas of your body? __ Yes ___ No 7. What makes the pain better or worse? (Time of day, movement, activities, etc.) 8. Prior interventions: (What have you done to relieve the symptoms? Mark "X" all that apply) ___ Prescription medications ___ Over-the-counter drugs ___ Acupuncture ___ Surgery Illness, operations, injuries, changes in health since last evaluation? ____Yes ____No

For office use:

SPC 410 Aiea, HI 96701

If yes explain: _____



		No	Mild	Moderate	Severe		No	Mild	Moderate	Sever
		Effect	Effect	Effect	Effect		Effect	Effect	Effect	Effec
	Sitting					Getting in/out of car				
	Standing					Reaching overhead				
	Walking Lying Down					Caring for family				
					Household chores					
	Exercising	Exercising	_		_ _	Lifting objects Dressing myself				
	Bending over									
	Climbing					Looking over				
	stairs					shoulder				
•	Rising out of					Showering or bathing				
	chair					Using a computer				
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